6-1800-11746-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Immediate Suspension of the License of Maureena Smith to Provide Family Day Care.
License # 221335

FINDINGS OF FACT, CONCLUSIONS AND RECOMMENDATION

A contested case hearing in this matter was held on July 8, 1998, in Minneapolis. The record closed at the end of the hearing on July 8.

Vicki Vial-Taylor, Assistant Hennepin County Attorney, 525 Portland Ave., Suite 1210, Minneapolis, Minnesota 55415, represented the Department of Human Services. David E. Albright, Attorney at Law, 7814 - 131st Street West, Apple Valley, Minnesota 55124, represented the Respondent, Maureena Smith.

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after reviewing the hearing record. The Commissioner may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendations. Under Minnesota law,[1] the Commissioner may not make his final decision until after the parties have had access to this report for at least ten days. During that time, the Commissioner must give each party adversely affected by this report an opportunity to file exceptions and present argument to him. Parties should contact the office of David Doth, Commissioner, Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, Minnesota 55155-3842, to find out how to file exceptions or present argument.

STATEMENT OF THE ISSUE

Whether the Department of Human Services' Order of Immediate Suspension of Maureena Smith's family day care license should be affirmed because the children in the day care were in imminent danger.

Based upon the record in this matter, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Procedural History

1. Ms. Maureena Smith was first licensed in July of 1996 to operate a family day care facility. The facility has been operated since then in a single family home at 3614 Oakland Avenue South in Minneapolis.

2. On April 9, 1998, the Hennepin County Children and Family Services Department recommended to the Minnesota Department of Human Services that Ms. Smith's family day care license be immediately suspended. The immediate suspension was based on Minnesota Rules 9502.0341, subp.9; 9502.0315 to 9502.0445; and 9543.0100, subp. 2.[2] Included with letter of recommendation were two attachments describing the events that went on at Ms. Smith's day care business during an investigation that morning.

3. On April 10, 1998, the Minnesota Department of Human Services issued an Order of Immediate Suspension. On April 11, 1998, Ms. Smith appealed the Order by a signed letter.[3]

4. On April 17, 1998, a Notice and Order for Hearing was issued by the Department, setting a hearing date of July 8.

5. On June 24, a prehearing conference telephone call was conducted by Administrative Law Judge Barbara Neilson. The purpose of the conference was to resolve the Department's request for an indefinite continuance of the hearing. Counsel for both the Department and Ms. Smith spoke to the motion at some length. Judge Neilson denied the Department's request for an indefinite continuance, and the hearing did take place on July 8.

Events of March and April 1998

6. Ms. Smith is a former Assistant Teacher in the Minneapolis Public School District. She obtained a C-3 license to operate a day care business in July of 1996. A C-3 license allows her day care home to have no more than four infants and toddlers, of which no more than three shall be infants. A C-3 license also allows for a maximum of 14 children from the age of ten and under so long as there are at least two caregivers present.[4]

7. Ms. Smith employed four part-time workers: Katurah Coatie, age 21; Karla Tabor, age 21+; Finda, age 18; and Kia, age 18. In addition, Ms. Smith's own son, Kevin Heard, age 13, was employed very rarely.

8. On April 9, 1998, the Hennepin County Child Care Licensing Department received information that the Hennepin County Child Protection Agency and the Minneapolis Police Department-Child Abuse Unit were investigating an allegation of

child abuse/neglect in Ms. Smith's day care home resulting from an injury which occurred on March 30, 1998.

9. On March 30, 1998, M.H., a child who had just learned how to walk, was in the basement along with other infants and a caregiver. The caregiver took another child upstairs to the bathroom. M.H. began to come up the stairs alone. When the other child and the caregiver returned from the bathroom, the other child began to descend the stairs alone, with the caregiver staying at the top. The two children met on the stairs, and somehow M.H. fell or was pushed backwards down to the bottom of the stairs. That evening, M.H.'s mother (T.W.) came to pick up her daughter and was told by Ms. Smith that the child had either fallen down the stairs or had been pushed down the stairs by one of the other children. After taking the child home and discussing the injury with the child's father (A.H.) she took the child to the hospital at 6:30 p.m. The mother testified that there are normally two adults present whenever she picked her child up at the day care home.

10. There was a medical examination done (on M.H.) at Minneapolis Children's Hospital. The Medical Doctor reported that the child had "what appear to be" child bite marks on her face, back, and chest, bruising to both ears, a bump and an abrasion on her forehead, other marks on her head, and a mark on her arm.[5] Pictures were also taken of the bite marks and bruises on the child (M.H.).[6] These injuries are consistent with a fall down stairs, but, in addition, the child-size bite marks are consistent with biting. Ms. Smith was aware of the fall down the stairs but was unaware of any biting.

11. On April 9, 1998, there was an unannounced visit made to Ms. Smith's daycare home by one investigating Hennepin County Child Protection worker (M.M.) and a detective from the Minneapolis Police Child Abuse Unit (A.M.). They arrived at approximately 11:25 a.m. The front entrance was not in use and the investigators were required to use the back entrance of the house. The investigators observed and counted seven pre-school-age children playing unattended in the back yard. They knocked on the back door several times and received no response. Finally, one of the children from the back yard admitted them into the home.

12. The investigators entered the house, going into the kitchen. They observed and counted four toddler-aged children unattended in the kitchen. While the investigators were in the kitchen, a pit bull puppy came into the kitchen and began to bark at them. The dog walked around the kitchen, and one child cried hysterically every time the dog came near her. After being in the kitchen for approximately five minutes, one of the children went downstairs and notified an adult worker that there were people upstairs. The door from the kitchen to the basement stairs was open, and ungated. There was nothing to prevent one of the toddlers from falling down the stairs.

13. The worker came upstairs from the basement, and identified herself as Keturah Coatie, the day care assistant in charge. She was 21 years old. The investigators asked her where Ms. Smith was. Coatie replied that Ms. Smith was out

doing a “shift change”. They then asked if Coatie was left alone like this often for such “shift changes”, and Coatie replied, “yes”. The investigators asked Coatie if she needed help. Coatie stated that she did not. They asked her to contact Ms. Smith, which she did by telephone. Ms. Smith said she would get back as soon as she could.

14. Coatie and the two investigators then went down into the basement and counted six infants or toddlers in their cribs. When added to the other children already noted above, there were a total of 17 children in the day care facility. The investigators were so concerned about Coatie’s ability to safely oversee so many children in three different locations (the back yard, the kitchen and the basement) that they called a squad car for backup, and discussed the possibility of immediately removing all of the children from the facility.

15. At approximately 11:55 a.m., Ms. Smith returned to the facility, bringing with her two other day care workers and an additional child. As soon as they arrived, all the workers began to get lunch ready and prepare the children for lunch. There were parents and children coming and going, and all witnesses agreed that it was quite hectic at the time. Ms. Smith was in a hurry to get the children fed, and did not have time to discuss the supervision issues or the injuries to M.H. with the investigators. She agreed to give an interview on the following day.

16. Sgt. McCandless took Ms. Smith’s files on the children, her attendance register, her day care license and other business and personal records from the facility back to her office. These were taken in order to determine whether the number of children in the home was within the required limits.[7]

17. There is a dispute in the testimony with regard to how many day care children and workers were in the home at various times. The Administrative Law Judge finds that at the time the investigators arrived at the facility, there were seven children in the back yard, four in the kitchen, and six in the basement. Three of the children arrived unexpectedly, after Ms. Smith had left the facility, and Coatie did not know what to do other than to accept them until Ms. Smith returned. Keturah Coatie was the only worker present until Ms. Smith returned with two other workers (plus one more child). See Memorandum.

Based on the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. Minnesota law[8] gives the Administrative Law Judge and the Department of Human Services authority to conduct this proceeding and to make findings, conclusions, and orders.

2. The Department of Human Services has complied with all of the law’s substantive and procedural requirements.

3. The Department gave Ms. Smith proper and timely notice of the hearing in this matter.

4. Minn. Stat. § 245A.07, subd. 2, provides in pertinent part, as follows:

> If the license holder's failure to comply with applicable law or rule has placed the health, safety, or rights of persons served by the program in imminent danger, the Commissioner shall act immediately to suspend the license.

5. Minn. Rule pt. 9543.1010, subp. 8 provides:

> "Imminent danger" means a child or vulnerable adult is threatened with immediate and present abuse or neglect that is life-threatening or likely to result in abandonment, sexual abuse, or serious physical injury.

6. The conduct of Ms. Maureena Smith in operating her day care facility on April 9, 1998 did place at least some of the children in imminent danger based on inadequate supervision at the facility. There were too many children and too few caregivers, in violation of Minn. Rule pt. 9502.0365 - .0367.

7. The Department's evidence did demonstrate the "reasonable cause" required to sustain the immediate suspension of Ms. Smith's day care license. This caused the burden of proof to shift to Ms. Smith pursuant to Minn. Stat. § 245A.08, subd. 3.

8. Ms. Smith did not demonstrate, by a preponderance of the evidence, that she was in full compliance with the laws or rules governing her day care facility.

RECOMMENDATION

The Administrative Law Judge recommends that the Commissioner of Human Services AFFIRM the immediate suspension of Ms. Maureena Smith's day care license, and proceed to take permanent disciplinary action against the license within a reasonably short period of time.

Dated this 23rd day of July, 1998.

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Allan W. Klein
Administrative Law Judge

NOTICE

Pursuant to Minn. Stat. § 14.62, subd. 1, the Commissioner must serve his final decision upon each party and the Administrative Law Judge by first-class mail.

MEMORANDUM

There are a number of matters which the Administrative Law Judge would like to clarify for the benefit of the Commissioner.

I.

First of all, there were a number of disputes in the testimony. There is a dispute about how many children were present when the investigators arrived. The Administrative Law Judge resolves that dispute in favor of the investigators, because he credits their explicit testimony that they carefully counted the number of children in the back yard, the kitchen and the basement. At the hearing, one of the investigators was sequestered, so that she could not hear the testimony of the other. Their testimony was nevertheless remarkably consistent. Their testimony was also consistent with the written reports which they prepared soon after April 9. While it is possible that three of the children were unexpectedly present in the facility, the facility was still over-capacity even without them, because there was only one caregiver.

The second dispute is whether Kevin Heard, Ms. Smith's 13-year-old son, can be counted as a second caregiver or helper. It was alleged by him and Keturah Coatie that he was in the back yard, watching the children there. But the investigators do not recall seeing him at all in the back yard, despite the fact that they were there for some time before entering the house. Kevin is five feet three inches tall, and weighs 115 pounds. He is, therefore, larger and more noticeable than most preschool children. There is no reason why the investigators would not have noticed him if he had been there. Moreover, the testimony is consistent about the fact that he did not approach them when they entered the back yard or knocked on the door. Kevin is a shy person, but the quality of his supervision must be questioned if he did not confront two strangers in his area of responsibility who were knocking on his door. Finally, at age 13, he only qualifies as a "helper", not a "caregiver" because of the definitions in Minn. Rule pt. 9502.0315. He cannot be used in place of a second caregiver if there is more than one infant or toddler present, because of Minn. Rule 9502.0365, subp. 4. Therefore, his presence or absence is of no impact on the question of overcrowding.

II.

The picture that emerges from hearing a full day's testimony and reviewing the records of the facility suggests that Ms. Smith was doing her best under difficult circumstances. Karla Tabor was scheduled to relieve Keturah Coatie at 1:00 on the afternoon of April 9. Ms. Tabor, however, has four children, and one of them was sick. She called Ms. Smith in the morning, and said she could not come. Ms. Smith then arranged for her two younger assistants, Finda and Kia, to come to the facility, but they needed a ride. Therefore, Ms. Smith left the facility (leaving only Keturah behind) to get the two assistants. Moreover, Keturah Coatie told the investigators, and testified at the hearing, that it was routine for Ms. Smith to pick up other workers and bring them to the facility, leaving Coatie alone with the children. This could occur up to three times a week, and take one hour each time. Ms. Smith testified that she had received permission from her Hennepin County licensing worker, Peter Sicoli, to be out of compliance with the staffing requirement in these circumstances, but Sicoli's superior, June Holmes, testified that Sicoli had no authority to grant such a variance, and that it would have to be done by his supervisor. There was no evidence of any such approval having been given for Ms. Smith's absences.

III.

The Administrative Law Judge has based his conclusions and recommendation primarily on the overcrowding and inadequate supervision which the investigation discovered on April 9. He is not basing them on the March 30 incident of M.H. falling down the stairs, nor on the bite marks found on her at the hospital. While those two facts are matters of concern, they are not the primary basis for the conclusions and recommendations. Instead, it is the overcrowding and inadequate supervision on April 9 which caused the children to be in imminent danger, justifying the immediate suspension.

AWK

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[1] Minn. Stat. § 14.61 (1997).

[2] See Exhibits #1, #2, and #6.

[3] See Exhibit #8.

[4] See Exhibit #18 and Minn. Rules pts. 9502.0365 - .0367.

[5] See Exhibit #3.

[6] See Exhibits #10-17.

[7] See Exhibit #18.

[8] Minn. Stat. §§ 14.50 and 245A.07, subd 2.